Massachusetts Board of Registration in Medicine

Annual Report to the General Court
Calendar Years 1994-1998

Board of Registration in Medicine, 10 West Street, Boston, MA 02111, 617-727-1788

Massachusetts Board of Registration in Medicine
Mission Statement

To ensure that only qualified physicians are licensed to practice in the Commonwealth, and to support an environment which maximizes the high quality of health care in Massachusetts.

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Enforcement Division

The vast majority of Massachusetts physicians are competent and caring individuals who abide by the laws of the Commonwealth and the Board's regulations. When, however, a physician appears unable or unwilling to maintain acceptable standards of medical practice, the Board is empowered to investigate, and, in appropriate circumstances, initiate formal disciplinary action to protect the public health, safety and welfare.

Staffing

In 1989, the Disciplinary Unit employed 15 full-time employees, consisting of six investigating attorneys, five prosecuting attorneys, a full-time complaint coordinator, two secretaries and a unit director. By 1990, the Commonwealth's fiscal crisis had resulted in the loss of four investigating attorneys and the complaint coordinator. The unit was functioning in 1990 at less than two-thirds of its previous staffing level. In 1991 and 1992, no staff were added and further attrition occurred; at one point, the unit as a whole had 8 full time employees, including only one investigator.

In 1992, the Legislature passed and the Governor signed into a law a measure that created a trust funded by 40% of the Board's revenue. The Board also raised physician license renewal fees from $150 biennially to $250. This infusion of resources permitted the Board to begin rebuilding its staff. Based upon lessons learned during the period of reduction of staff, the Board redesigned its disciplinary arm, creating an Enforcement Division consisting of two units, Litigation and Consumer Protection. The Litigation Unit, when fully staffed in the Spring of 1994, consisted of a Unit Chief, six and one-half full-time prosecutors, five Special Investigators, a paralegal, an intern and a secretary. The Consumer Protection Unit, fully staffed by the end of 1993, consisted of a Unit Chief, a Nurse Investigator, a Consumer Protection Officer, an administrator and a clerk. The Enforcement Division, including the Director, consists of seventeen and one-half full-time staff. In 1996, in response to a desire to focus more effectively on substandard care cases, the Board established a Clinical Care Unit, staffed by a nurse-attorney director and two full time nurse investigators.

Complaint Investigation

The Board, through its Complaint Committee and the staff of the Enforcement Division, investigates every allegation of substandard practice or violation of the medical law made by the public. Complaints are prioritized and resolved according a streamlined policy for complaint management adopted by the Board in 1992. The majority of all complaints are reviewed by a physician Board member or presented to the Complaint Committee, one member of which is a physician Board member, when the staff investigation is complete. The Committee may dismiss the complaint, with or without a Letter of Concern, may direct the staff to investigate further, may accept an informal, written probationary agreement called a Letter of Agreement, or may recommend that the Board commence formal disciplinary action.

Statutory Report Investigation

Many entities and individuals are required by law to report certain events to the Board's Data Repository. A Board committee considers these reports, and, when appropriate, refers them to the Enforcement Division for investigation. These files, once opened, are treated in a manner similar to complaints, although different rules regarding the confidentiality of the files apply.

The chart below illustrates the number of investigations of complaints and statutory reports opened and resolved during the years covered by this report.

Number of Investigations

	1994	1995	1996	1997	1998	TOTAL
Investigations Opened	513	569	432	399	403	2316
Investigations Closed	627	557	577	451	429	2641
TOTAL	**1140**	**1126**	**1009**	**850**	**832**	**4957**

Adjudicatory Proceedings

When the Complaint Committee recommends that the Board consider initiating formal disciplinary action against a physician, the investigative file is assigned to a Complaint Counsel who drafts an order to show cause why the physician should not be disciplined ("Statement of Allegations"). The Statement of Allegations is presented to the Board for its consideration; the Board may return the Statement of Allegations to the Complaint Committee with directions to dismiss or to conduct further investigation of the matter, or may issue the Statement, thus commencing formal adjudicatory proceedings under the Commonwealth's Administrative Procedure Act, M.G.L. ch.30A.

Legislation passed in 1989 requires adjudicatory hearings commenced on or after July 1, 1990 to be conducted before magistrates within the Commonwealth's Division of Administrative Law Appeals, an agency within the Executive Office of Administration and Finance.

Disciplinary Activity

At the conclusion of the administrative fact finding process, the Board receives a recommended final decision from the magistrate, and, after the parties are given an opportunity to appear in person before the Board, issues a final decision and order.

Occasionally, the Board may seek to resolve a disciplinary matter through negotiation of a Consent Order. Under these circumstances, the Respondent physician and Complaint counsel, under the supervision of the Complaint Committee, negotiate an agreed-upon statement of facts, conclusions of law and sanction. These documents are presented to the full Board as the recommendation of the Complaint Committee. The Board may accept the documents or reject all or part of them, in which case the matter is returned to the Complaint Committee

for further proceedings. Each Consent Order includes a Statement of Allegations. The chart below tracks the number of statements of allegations issued and physicians disciplined during the years covered by this report.

Statements of Allegations & Physician Discipline

	1994	1995	1996	1997	1998	TOTAL
Statements Issued	48	41	57	34	37	217
Physicians Disciplined	42	56	62	48	51	259

Consumer Protection Unit

The Consumer Protection Unit is responsible for maintaining accurate records on all cases opened and closed by the Board. This unit is the main liaison with the public. Its staff of 4 FTEs handle 4,000 calls annually. The staff is responsible for in-take of consumer complaints, educating the public of its rights and for sending forms and other public documents.

The Consumer Protection Unit is also responsible for tracking all open cases at the Board. It is the repository for, and reviews, each of the approximately 700 complaints the Board receives annually. It is responsible for making sure doctors respond to the allegations and that cases are monitored when assigned to investigators and/or attorneys.

Clinical Care Unit

The Clinical Care Unit (CCU) an all-nurse subdivision of the Enforcement Division, was created in April 1996. The CCU investigates reports of substandard care and collaborates with others in providing members of the Board with sufficient information in determining appropriate responses those reports.

Licensing Division

The Licensing Division's work is essential to ensuring that only qualified and competent physicians are licensed to practice medicine in Massachusetts. All physicians practicing medicine in the Commonwealth of Massachusetts must hold a valid medical license. Applicants for licensure may be recent medical school graduates, entering training programs in Massachusetts's institutions, or physicians already licensed in another state that have accepted a position in the Commonwealth.

The Licensing Division is responsible for the processing of each application in accordance with the Board's licensing regulations, 243 CMR 2.03. Individual license applications questioned to be in compliance with the Board's regulations are analyzed by a licensing attorney and where necessary are reviewed by Board members serving on the Licensing Committee.

Cognizant of the needs of hospitals, who have trainees entering onto programs, and also of the needs of physicians who have accepted positions in Massachusetts, Board staff work hard to process applications promptly.

Total Number of Licensed Physicians

Full	Limited	Inactive	TOTAL
26,242	8,518	1,732	36,492

Categories of Licensure

Limited License

A limited license enables a physician to obtain training in an ACGME-approved program in a Massachusetts hospital or other health care facility in the Commonwealth. The physician with a limited license may only practice medicine in the designated program and its affiliates. The Licensing Division staff and Residency Program Coordinators at the teaching hospitals work together to ensure that all qualified applicants are approved for licensure prior to their training start dates. A limited license certificate, specific to hospital and training program, is generated for each applicant. Annual Limited License Workshops are held in various locations in the Commonwealth to provide an education resource for Residency Program Coordinators on limited application revisions and legal issues, and to ensure that we are meeting the needs of the training programs.

Full License

Full licensure allows a qualified physician to practice medicine in the Commonwealth without restriction. All applicants for a full license must meet the Board's criteria for pre-medical and medical education and fulfill the postgraduate training requirements.

Eligibility requirements include two years of pre-medical education, a minimum of four years of medical school education, and a M.D. or D.O. degree. Candidates for full licensure who are

graduates of medical schools in Canada and the United States must have one year of training in an ACGME-accredited training program. Graduates of international medical schools are required to have two years of post graduate training in an ACGME-accredited training program the United States or Canada. All physicians requesting full licensure must have passed a qualifying examination, i.e. USMLE Steps 1, 2 and 3, National Boards, FLEX, LMCC, or a State Exam if taken prior to 1970.

Temporary License

Temporary licensure may be granted to a qualified physician who is licensed to practice in another state or territory or in the District of Columbia or in another country seeking a license for the following reasons:

(A) To accept a temporary faculty appointment certified by the Dean of a medical school in Massachusetts for purposes of medical education in an accredited hospital associated with the medical school. This license is granted for a maximum of three years, renewable at eight-month intervals.

(B) To permit a physician to act as a substitute physician for a Massachusetts practicing physician. This license is granted for a maximum of three months.

(C) To permit a physician to enroll in a course of continuing medical education in Massachusetts for a maximum of three months.

(D) To permit a physician to serve as visiting faculty member in an accredited hospital associated with a medical school in Massachusetts for not more than thirty days.

Renewals

Physicians with full licensure in Massachusetts are subject to renewal of their license every two years on their birthdate. Renewal requirements include fulfillment of a fixed number of continuing medical education credits to maintain an active license. Inactive status may be granted to physicians with a Massachusetts license who are not practicing medicine in the Commonwealth. A physician on inactive status may return to active status by acquiring the required CME credits.

Initial Licenses and Renewals for 1994-1998

	1994	1995	1996	1997	1998	TOTAL
Full Initials	1709	1538	1717	1548	1669	8181
Full Renewals	3853	21,121	4793	21,129	5607	56,503
Limited Initial	1172	1476	1982	1398	1431	7459
Limited Renewals	1015	1394	1779	2454	2512	9154
Temporary	40	33	27	16	11	127
TOTAL	**7789**	**25,562**	**10,29 8**	**26,545**	**11,230**	**81,424**

License Verification

Licensing Division staff process license verification requests from health care facilities and state medical boards by confirming the license status of a physician who held or holds a Massachusetts license. The following numbers illustrate the written verifications for the years 1994-1998.

Licensing Verifications 1994-1998

1993	1994	1995	1996	1997	1998
3,992	3,787	4,443	4,744	5,006	6,015

From 1994 to November, 1998, two Licensing Division staff members were assigned to provide written and verbal license verifications for prompt license status services to health care facilities, consumers and physicians. As of November 1, 1998, on-line verification of a physician's license status was made available to health care facilities and consumers on the Board's web site. The information on the web site is updated daily. Both the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) have approved our state of the art on-line system as primary source verification of physician licensure. More importantly, the on-line system has allowed the Licensing Division to reallocate 1 FTE to other job duties.

General Information

The licensing staff also provides information to applicants, hospitals, state medical boards, and the public concerning licensing requirements, rules and regulations. On a yearly basis, the licensing staff has contact with nearly every one of the state's hospitals and clinics. In addition, its staff regularly communicates with medical boards throughout the country, the Educational Council for Foreign Medical Graduates and the Federation of State Medical Boards. The General Counsel and Assistant General Counsel, ensure the legality of the licensing procedures and appropriately guide and advise licensing staff.

Patient Care Assessment

The Patient Care Assessment Committee (PCA) and Division at the Board of Registration in Medicine have responsibility for and implement the "PCA Regulations" (243 CMR 3.00), that require most health care facilities in the Commonwealth to establish and maintain quality assurance/risk management programs. The PCA Committee, a subcommittee of the of the full Board, consists of three physician Board members and one volunteer physician consultant. The PCA Committee oversees the PCA Division, a discrete unit at the Board, which currently consists of 2.4 FTE staff members with backgrounds in law, nursing and health policy.

The PCA Division's responsibility for institutional quality assurance (QA) was mandated by the Medical Malpractice Reform Act of 1986 and is unique among the nation's state licensing boards. The rationale for its existence at the Board is the fundamental principle that without physician leadership and participation, institutional quality assurance systems cannot and will not be successful. In addition to calling for physician participation, the PCA regulations also mandate that each facility's governing body assumes responsibility for institutional quality assurance.

There are over 800 health care facilities in the state that are effected by the PCA regulations; HMOs, MRI centers, university and school infirmaries and nursing homes. The regulations call for most of these facilities to establish quality assurance programs according to the requirements detailed in the PCA regulations. All quality assurance programs must be described in a written plan that is submitted to and reviewed by the PCA Division staff and ultimately approved by the Board. A Board-approved quality assurance plan is condition of hospital licensure; moreover, no licensed physician in the state may work at a health care facility that does not have an approved PCA plan.

A large part of the PCA Division's efforts in implementing the regulatory requirements is providing technical assistance to regulated facilities. This technical assistance can include, among other things, interpreting and explaining the regulations, clarifying reporting requirements, and providing advice when unique situations arise.

In addition to a PCA plan, the regulations require the submission of periodic reports from facilities. Every six months, hospitals, clinics, MRI centers and infirmaries must prepare a "PCA Semi-Annual Report" for their governing body, and also submit a copy to the Board. In the report, the facility summarizes the status of its PCA program, provides data on its internal incident reporting system and makes recommendations for quality assurance, risk management and employee education. Further, every year, the facilities listed above and HMOs must submit a "PCA Annual Report". The PCA annual report must contain specific information, such as a summary of the facility's patient complaints and their disposition, a list of all physicians who have terminated their relationship with the institution and how the facility handled any impaired health care providers. Division staff reviews each of these semi-annual and annual reports, more than 750 reports per year, for completeness and compliance with the regulatory requirements.

The most important tool the Division currently uses to ensure that a facility's PCA program is functioning effectively is the review of major incident reports. All regulated health care

facilities must submit an in-depth report on serious, unexpected patient outcomes known as "major incidents". Since the promulgation of the PCA regulations in 1986 through 1998, the Division has received approximately 6,450 major incident reports. The table below contains data on major incident reports submitted from 1994 through 1998.

Major Incident Reports: 1994-1998

Year	Number of Reports
1994	425
1995	463
1996	509
1997	521
1998	554

In 1996, the PCA Division embarked on a project to revise the section of the PCA regulations that defines major incidents. One of the catalysts for the endeavor was the complaint voiced by some health care facilities that the then current definition of major incidents, which had been in place since 1987, was confusing and resulted in under-reporting of events. After several meetings with representatives of the Massachusetts Hospital Association (MHA), a public hearing and a public briefing, the new regulation was adopted by the Board in December 1997.

During 1998, prior to the actual effective date of the regulation, the PCA Committee and staff prepared materials to accompany the new regulation. These materials included a new, clearer, reporting form with revised instructions, and a booklet entitled, "The Patient Care Assessment Function and the Program to Report Major Incidents".

When reporting a major incident, facilities must submit a clinical description of the event, the results of their internal investigation, and if applicable, any corrective measures taken to prevent a recurrence. The focus of the Division's review is the response of the reporting facility's PCA program to a serious, unexpected event, the rationale being that a good measure of a well functioning QA program is an appropriate and adequate response to such an adverse outcome.

As part of its review of major incidents, the Division works closely with the reporting facility. If the PCA Committee is not satisfied with the facility's response to an event, it can recommend a number of actions to be taken by the institution. These recommendations have included changes in internal policies or procedures, additional staff training or monitoring, an entire re-review of an event, a cessation of specific surgical or diagnostic procedures, and the procurement of an outside QA consultant.

If the PCA Committee remains dissatisfied, it calls for a meeting with the chair of the facility's board of trustees, the CEO, the chiefs of the major clinical departments, and any other appropriate personnel to discuss its concerns and to recommend solutions. From 1994 through 1998, the PCA Committee held 12 such meetings.

In addition to its intense facility-specific review of adverse events, the PCA Division is in a unique position to identify quality assurance problems in health care that require broad attention. If a statewide problem is ascertained from its analysis and trending of major incidents, staff conducts further research of the issue, including contacting experts, reviewing available literature, and conducting surveys. The Division then responds to the problem, either through issuance to all facilities of a QA advisory known as a "*PCA Update*" or more detailed "PCA Guidelines". *PCA Updates* describe the QA problem, the results of the Division's research and then offer a possible solution. Between 1994 and 1998, the Division issued three such *Updates*. In 1997, the Division warned hospitals about the dangers of high concentrations of potassium chloride administered through central intravenous lines. In January, 1998, a *PCA Update* described the risks of carrying out major pediatric neurosurgical procedures in hospitals without specialized units. And in October, 1998, an *Update* reminded facilities about the problems patients who have been previously treated with steroids can encounter when they undergo stress from trauma, surgery or other acute medical conditions. In 1994, in response to a series of patient deaths related to the administration of intravenous conscious sedation, the Division formed a multidisciplinary panel, which assisted the Division in formulating in-depth PCA guidelines (essentially, standards of care) on the subject and distributed them to all hospitals and clinics in the state. The Division received very positive feedback on this effort, both statewide and nationally, and still receives requests for the guidelines from individuals and institutions nationwide.

In summary, the Board's PCA Division, with a small staff of 2.4 FTEs and a dedicated group of physicians who serve on the PCA Committee, carries out an important and unique regulatory function. The work of the Division, which is intended not to usurp the quality assurance function at health care facilities but rather to empower those facilities to perform and strengthen their own internal QA activities, has improved patient care in the state. With very few resources, the PCA Division has made and continues to make a difference in the quality of health care services delivered in the Commonwealth.

In 1998, the work of the Division was featured in the October 28th issue of the *Journal of the American Medical Association (JAMA*, Vol. 280, No.16, October 28, 1998). In the issue, there was a discussion of, "...4 bold initiatives that incorporate the management of medical error into comprehensive strategies to promote safety." The PCA Division's effort was one of the four highlighted initiatives. Soon thereafter, NBC News reported on the *JAMA* article in an evening newscast; the work of the PCA Division was cited as being a national model for reporting medical errors.

Data Repository

The Board's Data Repository is the central bank for medical malpractice and other data statutorily mandated to be reported regarding physicians licensed in the Commonwealth. Data repository staff works with the Board members serving on the Data Repository Committee to review mandated reports to determine which should be investigated further by the Enforcement Division and to develop policies relating to particular types of reports or classes of information.

In addition, the Data Repository is responsible for ensuring that mandated reporters file timely and complete reports, investigating reports prior to their review by the Data Repository Committee and disseminating information regarding Board disciplinary actions to national data collection systems and other interested parties.

Closed Claim Reports

The Commonwealth's medical malpractice insurers must file a closed claim report within 30 days after a judgment, settlement, arbitration award or other final disposition not resulting in payment is reached.

Court Reports

Court clerks must send the Board copies of the complaint and medical malpractice tribunal results within 15 days of the tribunal finding. Copies of judgements, settlements, or other final dispositions at the trial court level are required to be sent within 15 days of their entry.

Health Care Facility Disciplinary Action Reports

Health care facilities, including hospitals, clinics, nursing homes and HMOs, must file initial, subsequent and annual reports that explain certain actions taken against physicians (the Board's definition of "disciplinary action" can be found at 243 CMR 3.02). Reports are required within 30 days after discipline is imposed or follow-up action occurs and when an ongoing action has been completed. An annual summary of physician discipline must be filed each calendar year, even if no such actions were taken by the facility.

Government Employee and Health Care Provider Reports

Government employees engaged in the provision or oversight of any medical or health services must report to the Board when they are aware that a physician has violated General Laws chapter 112, §5 or the Board's regulations. Certain health care providers, including physicians, dentists and nurses, are required to report under the same circumstances, unless the alleged violation relates to impairment by alcohol or controlled substances and the physician is undergoing treatment.

Professional Medical Association Disciplinary Action Reports

Professional medical associations are required to report disciplinary actions taken against physicians within 30 days. This requirement applies to local, regional, statewide, national and international associations.

Criminal Courts

Court clerks must forward copies of the court proceedings within one week whenever a physician pleads guilty to any crime, is adjudged guilty by a court of competent jurisdiction, pleads *nolo contendere,* or where sufficient facts of guilt were found and the matter was continued without a finding.

Mandated Reports received by Data Repository

Report Type	1994	1995	1996	1997	1998	TOTAL
Professional Organization Disciplinary Actions	5	1	0	2	1	9
Government Employee reports	2	9	16	43	25	95
Peer Reports	26	18	18	24	15	101
Initial Disciplinary Actions	58	69	65	57	70	319
Subsequent Disciplinary Actions	47	46	64	65	27	249
Closed Claim Reports	865	830	847	893	906	4341
Malpractice Court Reports	544	586	678	710	959	3477
Criminal Convictions	0	1	2	5	10	18
TOTAL	**1547**	**1560**	**1690**	**1799**	**2013**	**8609**

Committee on Acupuncture

Acupuncturists were first allowed to practice in Massachusetts in 1973 under a Board regulation that required an acupuncturist to be a physician or in the employ of a physician. In 1977, this regulation was amended to allow Board-registered acupuncturists to practice in conjunction with supervising physicians, whose role was to give patients preliminary examinations and written referrals for acupuncture treatment.

In January of 1988, regulations were promulgated to allow acupuncturists to become licensed in Massachusetts for the first time. The Committee on Acupuncture held its first licensure exam and issued its first licenses in 1988 and has since granted 696 licenses.

Committee members are appointed by the Board, and include four acupuncturists, one physician with acupuncture experience, one public member, and one physician member of the Board. The Committee sets regulatory standards for licensure and practice, approves acupuncture schools and training programs, conducts licensure exams and disciplines acupuncturists who engage in malpractice or misconduct.

The Committee is aided by staff that handle questions from the public and acupuncture professionals, and work with other Board divisions, most notably the Enforcement and Legal Divisions.

Licensure Exam

The Massachusetts Licensure Examination consists of three (3) parts: The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Comprehensive Written Examination (CWE); the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Practice Examination of Point Location Skills Examination (PEPLS), and the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) Clean Needle Technique.

Following is a table showing the number of acupuncture applicants licensed and the number of renewal applications for full licenses processed each year since 1994.

	1994	1995	1996	1997	1998	TOTAL
Applicants Licensed	35	50	62	61	56	264
Renewal Applications	230	145	238	158	343	1114
TOTAL	**265**	**195**	**300**	**219**	**399**	**1378**

Physician Profiles

In July, 1996 the Massachusetts Legislature enacted what is known as the Physician Profiles Law. The law, which became effective on November 6, 1996, set a new national standard for the provision of information to health care consumers by their state medical board. The legislation provided that the Massachusetts Board of Registration in Medicine would provide to the public a profile on each of the 28,000 physicians licensed to practice in the state. As conceptualized by the drafters of the bill, and implemented by the Massachusetts Board, each profile would contain information that would aid consumers in making better informed choices about physicians. The profile of each physician contains information about a physician's practice, education, awards, publications, hospital or Board discipline, malpractice payments, and criminal convictions.

In preparation for the implementation of law, Board staff spent several months working with physicians, organized medicine, medical malpractice insurers, and health care facilities to ensure that the data collected and held by the Board was accurate and understandable to the public. During that time, the Board's computer staff developed dozens of applications to manage the millions of data elements, and to develop a readable and informative format for each physician profile. On November 6, 1996, the Board began to receive requests for profiles, and will fax or mail as many as ten to each requesting person. On May 1, 1997, the Board's Physician Profile became accessible through the Internet, increasing access to this product to millions of people worldwide.

The response to physician profiles was immediate and heavy. The first month, the Board received 10,700 requests, and provided 15,652 profiles. Following the initiation of Internet availability, the numbers increased geometrically.

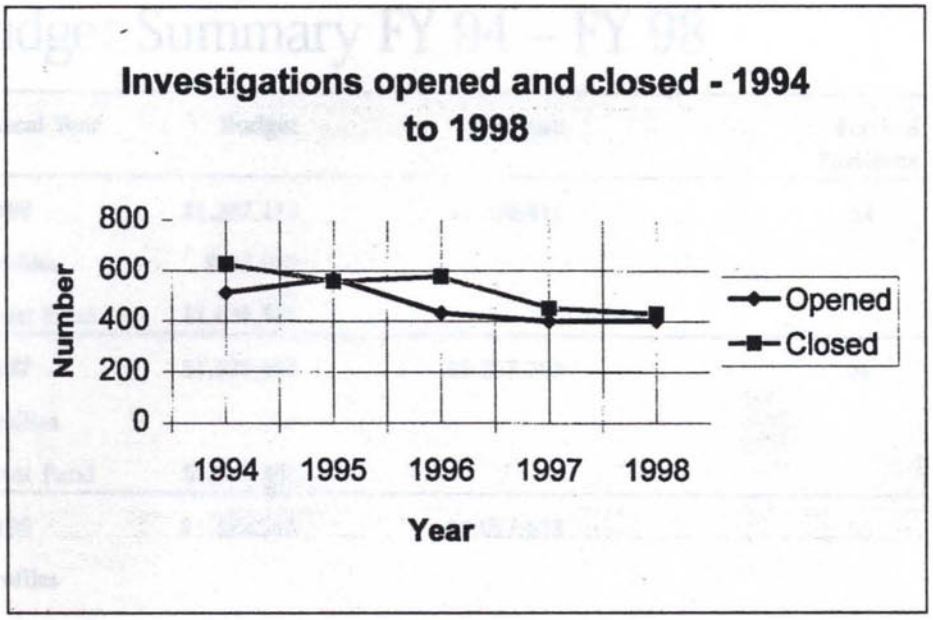
The impact of the Board's first-in-the-nation Physician Profiles program went beyond the borders of Massachusetts. As soon as the program began, the Board received requests from state legislatures and medical boards across the country for assistance in establishing their own programs, modeled after Massachusetts'. On June 15, 1998, the Massachusetts Board hosted representatives from 13 other state boards in at a day-long conference on the issues and methods of implementation of the Profiles law.

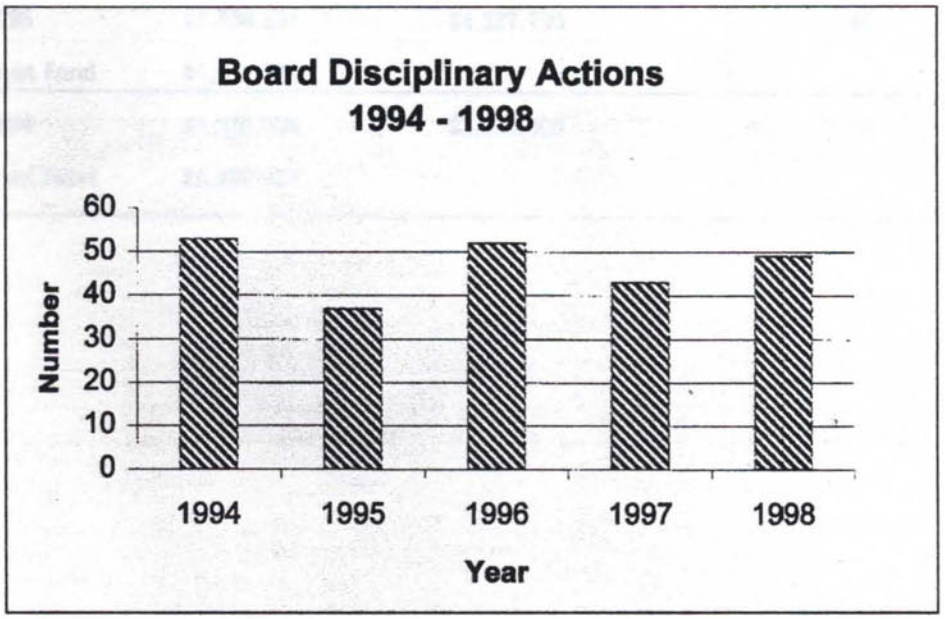
In the three years since the start of the Profiles program, the Board has continued to work on the formatting, the information, and availability to the public of the physician profiles.

Physician Profiles Output Summary

Year	Calls Received	Profiles Provided
1996	17,127	25,771
1997	43,698	57,619
1998	30,085	32,316
Total	**90,910**	**115,706**

List of Attachments


Investigations opened and closed - 1994 to 1998
800
600
400
200
0
Number
1994
1995
1996
1997
1998
Year
Opened
Closed


Board Disciplinary Actions 1994 - 1998
60
50
40
30
20
10
0
Number
1994
1995
1996
1997
1998
Year

Board of Registration in Medicine Budget Summary FY 94 – FY 98

Fiscal Year	Budget	Revenue	Funded Positions
FY98	$1,387,113	$4,136,411	54
Profiles	$247,000		
Trust Fund	$1,638,501		
FY97	$1,525,464	$5,237,282	56
Profiles	0		
Trust Fund	$1,814,467		
FY96	$1,528,393	$3,977,538	55
Profiles	0		
Trust Fund	$1,572,515		
FY95	$1,559,837	$4,527,796	46
Trust Fund	$1,691,717		
FY94	$1,546,008	$3,650,000	45
Trust Fund	$1,470,921		

Committee on Acupuncture

John G. Meyerson, Ph.D.
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Weidong Lu
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Wen Juan Chen
Secretary

Nancy Lipman

Amy Soisson, J.D.